Before the
Administrative Hearing Commission
State of Missouri

SOUTHAVEN, INC.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 13-1132 SP
	)	
DEPARTMENT OF SOCIAL SERVICES, MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT,	)	
	)	
Respondent.	)	

DECISION

We find that Southaven, Inc., ("Southaven") was overpaid $43,524.10 under the Missouri Medicaid Program. We authorize the Department of Social Services, Missouri Medicaid Audit and Compliance Unit ("the Department") to recoup this amount, and order provider education regarding adequate documentation.

Procedure

On June 20, 2013, Southaven filed a complaint appealing a decision by the Department that it was overpaid $43,524.10. On June 28, 2013, Southaven filed a motion for stay. On July 19, 2013, we held a stay hearing and issued an order granting the stay effective upon the filing of a bond. On September 20, 2013, the bond was filed. On July 24, 2013, the Department filed an answer.

We held the hearing on January 30, 2014. Jacquelyn Brazas, with Riley & Dunlap, P.C., represented Southaven. Assistant Attorney General Matthew J. Laudano represented the Department. On April 9, 2014, Brazas filed a waiver on behalf of Southaven of the 300-day deadline imposed by § 208.221[1], and withdrew as counsel for Southaven. The matter became ready for our decision on June 20, 2014, the date the last written argument was due.

On August 27, 2014, the case was transferred to Commissioner Karen A. Winn, who, having read the full record including all the evidence, renders the decision. Section 536.080.2; *Angelos v. State Bd. of Regis'n for the Healing Arts*, 90 S.W.3d 189 (Mo. App., S.D. 2002).

Findings of Fact

1. Southaven, Inc. was, for all time periods relevant to this case, a MO HealthNet personal care services provider operating a residential care facility. Gina Stoverink was the president of the corporation and the administrator of Southaven at all relevant times.

2. Southaven held a Title XIX participation agreement with the Department of Social Services, and held such an agreement for all relevant times. Stoverink owned another facility in Kennett, Missouri. She previously had a minor Medicaid billing problem at that facility in that she accidentally billed for the wrong patient on one occasion.

3. Southaven's Title XIX participation agreement in effect for the relevant time period in this case required that Southaven would "be financially responsible for all services which are not documented." Southaven also agreed that it would "comply with the Medicaid manual, bulletins, rules and regulations . . . in the delivery of services and merchandise and in submitting claims for payment. I understand that in my field of participation I am not entitled to Medicaid reimbursement if I fail to so comply[.]" Respondent's Ex. B at 3.

[1] Statutory references, unless otherwise noted, are to the 2000 Revised Statutes of Missouri.

4. Southaven further agreed that:

> All services billed through the Medicaid Program are subject to post-payment review. This may include unannounced on-site review of records. Failure to submit or failure to retain documentation for all services billed to the Medicaid Program may result in recovery of payments for Medicaid services and may result in sanctions to the provider's Medicaid participation[.]

Id. at #6 (emphasis in original).

5. On December 14, 2011, the Department conducted a post-payment review[2] of Southaven's Medicaid claims for dates of service from January 1, 2011, through June 30, 2011. The Department randomly selected Southaven's facility for this post-payment review. The Department focused its review on certain clients. The Department informed Southaven of this post-payment review by a letter dated December 9, 2011 that was hand-delivered to the facility.

6. On December 14, 2011, the Department's representatives, Missy Birdsong and Janet Massman, traveled to Southaven's facility to perform the on-site portion of the post-payment review. Upon arrival, the Department provided information about the audit to Southaven's representative.

7. Following that presentation, a Southaven employee accompanied Birdsong and Massman to the facility's dining room, where they set up a laptop and scanner for the collection of documents.

8. Southaven's staff then produced several client-related documents. Massman scanned those documents and ensured that the scans were accurate.

9. During this process, Birdsong and Massman questioned Southaven's nurse about a concern that signatures on certain personal care documents were not originals. She told them that Southaven did not have clients sign and verify personal care logs. Instead, Southaven

[2] Also called an "audit" in this decision.

obtained a signature on a blank log-in sheet upon the admission of the clients to the facility, and copied that document each month for use by its staff. The client did not subsequently sign and verify the personal care services he or she received. Exhibit G is an example of such a blank, signed personal care log.

10. Also during this process, Massman witnessed Southaven's nurse creating documents that purported to be personal care logs for the month of May from the audit period. Birdsong collected these documents. When she performed her review, Massman did not consider these documents because they were not created when the services were performed.

11. Afterward, Birdsong met with Stoverink. Stoverink initialed and signed a form affirming that she had "produced and disclosed all records, in their entirety[.]" Respondent's Ex. E at 4.

12. Following the collection of these documents, Massman performed a review.

13. The documents in Exhibit A constitute the monthly personal care logs regarding the clients and claims included in the audit that Southaven provided to the Department during the audit. The documents in Exhibit A did not contain daily signatures from any individual. The documents do contain one supervisor's signature, but it is not dated. The documents in Exhibit A do not contain signatures of aides. Some of the monthly personal care logs contain signatures of clients (one client signature per month) that have been copied as described in Finding of Fact 9.

14. The documents in Exhibit C constitute the nurse visit documentation regarding the clients and claims included in the audit that Southaven provided to the Department during the audit. The documents in Exhibit C gave no indication that Southaven's nurse visit was supervised, authorized, or validated by a registered nurse ("RN"), or that the nurse visit otherwise involved an RN. The documents in Exhibit C contain signatures of a client and a licensed practical nurse ("LPN"). Some of the nurse visit documents have been photocopied.

15. The documents in Exhibit D constitute the personal care plans regarding the clients included in the audit that Southaven provided to the Department during the audit. Massman noticed that Southaven's production of care plans failed to include all care plans needed for her review. Massman then ordered the missing care plans from the Department of Health and Senior Services.

16. Massman noticed during her review that the signatures found on the documents in Exhibit A and C appeared to be copies, not originally-executed signatures for each document.

17. Massman referred the case to the Department's investigations unit.

18. The Department's investigator David Lanigan reviewed the documents about which Massman had concerns. Lanigan, laying one page of Exhibit A from January through May of 2011 on top of another page and then holding those pages up to a bright light, noticed that the signatures found on most of these documents were exact duplicates of each other. Lanigan also observed where the signatures on these documents intersected with computer-printed images already on the page. Lanigan noticed that the signatures' intersections with these images were completely consistent for each page of Exhibit A from January through May of 2011. Lanigan also noticed this was true with regard to the handwritten checkmarks down the left side of the January through May logs in Exhibit A.

19. These portions of the records Lanigan reviewed were not originally executed, but were instead copies of some blank document on which these exact marks were made. "White-out" was used in the date section and a new date written over it.

20. Lanigan also reviewed the documents found in Exhibit C, using the same techniques he used in reviewing the documents found in Exhibit A. Lanigan found that the markings (other than the dates) and signatures on certain documents in this exhibit perfectly matched those of other documents in this exhibit. For example, the document purporting to be a

nurse visit record for client W.D. in April of 2011 exactly matches the document purporting to be a nurse visit record for W.D. in May of that year, except for the date. "White-out" was used in the date section and a new date written over it.

21. Lanigan interviewed Stoverink concerning issues raised by his investigation. Stoverink admitted to Lanigan that Southaven's employee created documents purporting to be personal care logs while the Department's auditors were on site.

22. A task authorized by a personal care plan to be performed daily cannot be performed in accordance with the care plan as many times in a month with less than 31 days as it can in a 31-day month.

23. By letter dated May 24, 2013, the Department assessed Southaven as follows for the following Error Types.[3]

> Error Type A: the documents do not include one of the following for the audited dates of service: the signature of the recipient; the mark of the recipient witnessed by at least one person; the signature of another responsible person (including the personal care aide's supervisor) present in the facility at the time of service; or, when the recipient is unable to sign and there is no other responsible person present, the personal care aide.
>
> Error Type C: the documents do not, for the audited dates of service, show that a LPN performed the asserted services under the direction of a RN.
>
> Error Type D: claims sought payment for the monthly maximum of personal care services provision during months having fewer than thirty-one days.
>
> Error Type E: the documentation provided by Southaven in support of these claims was not made at or near the time of the events purportedly recorded.
>
> Error Type F: Southaven failed to provide the Department with any documentation in support of these claims during the audit.

[3] We do not include Error Type B referenced in the letter because the Department did not pursue those allegations. Tr. at 123. Since Error Type B was always paired with another error type, its omission does not affect the determination of the amount of overpayment.

24. Southaven submitted and was paid for the following MO HealthNet claims.

Name	Date of Service	Error Code	Overpayment Amount
WD	2/1/11	A, D	$872.34
WD	3/1/11	A	872.34
WD	4/1/11	A, D	872.34
WD	5/1/11	A, E	872.34
WD	6/1/11	A	422.10
WD	6/16/11	A, D	450.24
CE	1/1/11	A	872.34
CE	2/1/11	A, D	872.34
CE	3/1/11	A	872.34
CE	4/1/11	A, D	872.34
CE	5/1/11	A, E	872.34
CE	6/1/11	A, D	872.34
DG	1/1/11	C	30.45
DG	1/1/11	A	1,069.32
DG	2/1/11	C	30.45
DG	2/1/11	A, D	1,069.32
DG	3/1/11	C	30.45
DG	3/1/11	A	1,069.32
DG	4/1/11	A, D	1,069.32
DG	4/1/11	C	30.45
DG	5/1/11	C	30.45
DG	5/1/11	A, E	1,069.32
DG	6/1/11	A, D	1,069.32
DG	6/1/11	C	30.45
BG	4/28/11	F	30.45
BG	4/28/11	A	13.56
BG	4/28/11	A	120.60
BG	5/1/11	A	140.12
BG	5/1/11	C	30.45
BG	5/1/11	A, E	1,121.58
BG	6/1/11	A, D	140.12
BG	6/1/11	C	30.45
BG	6/1/11	A, D	1,121.58
GH	1/1/11	A	747.72
GH	2/1/11	A, D	747.72
GH	3/1/11	A	747.72
GH	4/1/11	A, D	747.72
GH	5/1/11	A, E	747.72
GH	6/1/11	A, D	747.72
JH	1/1/11	A	249.24
JH	2/1/11	A, D	249.24

JH	3/1/11	A	249.24
JH	4/1/11	A, D	249.24
JH	5/1/11	A, E	249.24
JH	6/1/11	A, D	249.24
KK	5/4/11	F	30.45
KK	5/4/11	A, E	1,121.58
KK	5/4/11	A, E	420.36
KK	6/1/11	A, D	420.36
KK	6/1/11	C	30.45
KK	6/1/11	A, D	1,121.58
PL	1/1/11	A	747.72
PL	2/1/11	A, D	747.42
PL	3/1/11	A	747.42
PL	4/1/11	A, D	747.42
PL	5/1/11	A, E	747.42
PL	6/1/11	A, D	747.42
JS	3/8/11	A	820.08
JS	4/1/11	A, D	996.96
JS	5/1/11	A, E	996.96
JS	6/1/11	A, D	996.96
PS	1/1/11	A	872.34
PS	2/1/11	A	418.08
PS	2/23/11	A	192.96
PS	3/1/11	A	872.34
PS	4/1/11	A, D	872.34
PS	5/1/11	A, E	872.34
PS	6/1/11	A, D	872.34
LS	3/29/11	C	30.45
LS	3/29/11	A	100.50
LS	4/1/11	C	30.45
LS	4/1/11	A, D	996.96
LS	6/1/11	A, D	996.96
LS	6/1/11	C	30.45
TOTAL			$43,524.10

25. Based on his discussion with Stoverink, and his lack of proof that services had not actually been provided, Lanigan did not recommend pursuing charges of fraud against Southaven. He chose to find that these errors were administrative in nature rather than fraudulent "to give Southaven the benefit of the doubt here." Tr. at 136.

Conclusions of Law

We have jurisdiction to hear Southaven's complaint. Section 208.156.2 and § 621.055.1, RSMo Supp. 2013. We do not merely review the Department's decision, but we find facts and

make an independent decision by applying existing law to facts. *Department of Soc. Services v. Peace of Mind Adult Day Care Ctr.*, 377 S.W.3d 631, 639 (Mo. App., W.D. 2012). We have the same degree of discretion as the Department and need not exercise it the same way. *Id.*

Southaven has the burden of proof and must prove its case by a preponderance of the credible evidence. Section 621.055.1. We must judge the credibility of witnesses, and we have the discretion to believe all, part, or none of the testimony of any witness. *Dorman v. State Bd. of Reg'n for the Healing Arts*., 62 S.W.3d 446, 455 (Mo. App., W.D. 2001).

The Department has issued regulations governing Medicaid reimbursement pursuant to § 208.201, which states:

> 5. In addition to the powers, duties and functions vested in the division of medical services by other provisions of this chapter or by other laws of this state, the division of medical services shall have the power:
>
> * * *
>
> (8) To define, establish and implement the policies and procedures necessary to administer payments to providers under the medical assistance program[.]

Regulation 13 CSR 70-3.030[4] provides a definition of adequate documentation:

> (2) The following definitions will be used in administering this rule:
>
> (A) "Adequate documentation" means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered.
>
> * * *

[4] All references to "CSR" are to the Missouri Code of State Regulations as current with amendments included in the Missouri Register through the most recent update.

> (L) Records means any books, papers, journals, charts, treatment histories, medical histories, tests and laboratory results, photographs, X rays and any other recordings of data or information made by or caused to be made by a provider relating in any way to services provided to MO HealthNet participants and payments charged or received. MO HealthNet claim for payment information, appointment books, financial ledgers, financial journals, or any other kind of patient charge without corresponding adequate medication records do not constitute adequate documentation[.]

Regulation 13 CSR 70-3.030(3) lists program violations and states:

> (A) Sanctions may be imposed by the MO HealthNet agency against a provider for any one (1) or more of the following reasons:
>
> 2. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is entitled under applicable MO HealthNet program policies or rules, including, but not limited to, the billing or coding of services which results in payments in excess of the fee schedule for the service actually provided or billing or coding of services which results in payments in excess of the provider's charges to the general public for the same services or billing for higher level of service or increased number of units from those actually ordered or performed or both, or altering or falsifying medical records to obtain or verify a greater payment than authorized by a fee schedule or reimbursement plan;
>
> ***
>
> 4. Failing to make available, and disclosing to the MO HealthNet agency or its authorized gents, all records relating to services provided to MO HealthNet participants or records relating to MO HealthNet payments, whether or not the records are commingled with non-Title XIX (Medicaid) records. All records must be kept a minimum of five (5) years from the date of service unless a more specific provider regulation applies. The minimum five (5)-year retention of records requirement continues to apply in the event of a change of ownership or discontinuing enrollment in MO HealthNet. Services billed to the MO HealthNet agency that are not adequately documented in the patient's medical records or for which there is no record that services were performed shall be considered a violation of this section. Copies of records must be provided upon request of the MO HealthNet agency or its

authorized agents, regardless of the media in which they are kept. **Failure to make these records available on a timely basis at the same site at which the services were rendered or at the provider's address of record with the MO HealthNet agency, or failure to provide copies as requested, or failure to keep and make available adequate records which adequately document the services and payments shall constitute a violation of this section and shall be a reason for sanction.** Failure to send records, which have been requested via mail, within the specified time frame shall constitute a violation of this section and shall be a reason for sanction;

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7. Breaching of the terms of the MO HealthNet provider agreement of any current written and published policies and procedures of the MO HealthNet program (Such policies and procedures are contained in provider manuals or bulletins which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, September 15, 2009. This rule does not incorporate any subsequent amendments or additions.) or failing to comply with the terms of the provider certification on the MO HealthNet claim form;

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33. For providers other than long-term care facilities, failing to retain in legible form for at least five (5) years from the date of service, worksheets, financial records, appointment books, appointment calendars (for those providers who schedule patient/client appointments), adequate documentation of the service, and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. For long-term care providers, failing to retain in legible form, for at least seven (7) years from the date of service, worksheets, financial records, adequate documentation for the service(s), and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. The documentation must be maintained so as to protect it from damage or loss by fire, water, computer failure, theft, or any other cause;

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> 38. Failure to maintain documentation which is to be made contemporaneously to the date of service;
>
> 39. Failure to maintain records for services provided and all billing done under his/her provider number regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the MO HealthNet claim or both[.]

(Emphasis added.)

The Department has also issued regulations specifically governing the reimbursement of services provided under its personal care program, at 13 CSR 70-91.010 *et seq.* We set those at issue in this case out more particularly in our discussion below.

We note that in its answer (which includes the Department's final decision) and written argument, the Department alleges that errors A, C, D, E, and F are cause for sanctions under various sections of 13 CSR 70-3.030(3)(A) and 13 CSR 70-91.010 which we consider in this decision. The Department's answer lists a number of other sections in this regulation, but provides no explanation or written argument as to how Southaven violated those sections. Although the burden of proof is on Southaven in this case, if the Department asks us to find cause for sanctions under certain sections of law, then it should, at some point, specify how the conduct allegedly violated the particular law. Therefore, we do not address those sections of the regulation.

I. Violations

A. Error Type A – No Daily Client Signatures

Regulation 13 CSR 70-91.010 states:

> (4) Reimbursement.
>
> (A) Payment will be made in accordance with the fee per unit of service as defined and determined by the Division of Medical Services.

> 1. A unit of service is fifteen (15) minutes.
>
> 2. Documentation for services delivered by the provider must include the following:
>
> F. **For each date of service: the signature of the recipient, or the mark of the recipient witnessed by at least one (1) person, or the signature of another responsible person present in the recipient's home or licensed Residential Care Facility I or II at the time of service.** "Responsible person" may include the personal care aide's supervisor, if the supervisor is present in the home at the time of service delivery. The personal care aide may only sign on behalf of the recipient when the recipient is unable to sign and there is no other responsible person present.

(Emphasis added.)

The Department argues that Southaven violated 13 CSR 70-91.010(4)(A)2.F because the documents produced by Southaven during the audit in support of its personal care claims in this case do not include one of the following for the audited dates of service: the signature of the recipient, the mark of the recipient witnessed by at least one person, the signature of another responsible person (including the personal care aide's supervisor) present in the facility at the time of service, or, when the recipient is unable to sign and there is no other responsible person present, the personal care aide.

We agree with the Department that many of the clients' signatures on the personal care logs are clearly not original signatures.[5] The signatures are identical from month to month – evidence that the clients signed blank forms, and the forms were photocopied and the aides' initials were filled in as the services were provided. "White-out" was used in the date section and a new date written over it. Even if the signatures were original, the logs were monthly logs – with only one signature line for each client, not daily signatures as required by the regulation.

[5] The LPN's signature also appears to be copied, but the regulation does not require that signature.

In its complaint, Southaven alleges that we should accept the initials of the aides who performed the services each day as an acceptable signature. Stoverink testified that she keeps a master log sheet with the full names of the aides so she can identify them from their initials. Even if we accepted the initials, there was no evidence provided that the clients were unable to sign the logs or that there was no other responsible person present – the requirements under the regulation to substitute the aides' signatures for the clients' signatures.

Southaven argues that the Department is estopped from alleging these deficiencies because it approved the form in the past. Stoverink testified that she did not know of the requirement that the client sign the logs on a daily basis until after she was audited. Southaven appears to argue that the Department operated under different regulations or different interpretations of the regulations with regard to daily signatures in the past, but provided no evidence to support this contention. Our review of the history of 13 CSR 70-91.010 shows that it was amended last in 2005, long before the date of the on-site review. Stoverink provided no evidence about the Department's interpretation of the regulation or that the Department had given her incorrect information. Furthermore, Stoverink's lack of knowledge does not excuse the violation of the regulation.

Southaven violated 13 CSR 70-91.010(4)(A)2.F as set forth in our Finding of Fact #24 under Type A errors.

For these violations, the Department argues that Southaven is subject to sanctions under 70-3.030(3)(A)4 and 7.

4. Failing to keep and make available adequate records. Although Southaven timely and willingly made its records available to the Department, in a number of instances the Department found there was no documentation or inadequate documentation to support the services billed. This is cause to sanction Southaven under subsection 4.

7. Breaching of the terms of the MO HealthNet provider agreement or any current written and published policies and procedures of the MO HealthNet program. Southaven breached its provider agreement by violating Medicaid regulations. There is cause to sanction it under subsection 7.

B. Error Type C – No Evidence that RN Performed Services

Regulation 13 CSR 70-91.010 states:

> (6) Separately Authorized Nurses Visits.
>
> (A) The provisions of paragraphs (3)(J)1 and (3)(H)3. notwithstanding, reimbursement will be made for visits by a nurse to particular clients with special needs, when the visits are prior authorized by the Department of Health and Senior Services or its designee. Providers of personal care services must have the capacity to provide these authorized nurse visits in addition to the nonauthorized nurse visits required by subsection (3)(J); however, any client who receives an authorized nurse visit in one (1) month shall not be included in the population from which the ten percent (10%) sample for that month's supervisory visits is drawn in accordance with paragraph (3)(J)1. Anytime an authorized nurse visit is made, the nurse shall also, in addition to other duties, evaluate the adequacy of the plan of care, including a review of the plan of care with the recipient.
>
> ***
>
> (D) The services of the nurse shall provide increased supervision of the aide, assessment of the client's health and the suitability of the care plan to meet the client's needs. . . .
>
> [#1-#6 of the regulation refer to actions an **RN** may take.]
>
> ***
>
> 7. The visits authorized under section (6) except (6)(D)6 may be carried out by an LPN, if under the direction of an RN[.]
>
> ***
>
> (F) Documentation of the authorized nurse visit shall include written notes and observations. These will be maintained in the recipient's file. In addition, notes of any verbal communication

> and copies of any written communications with the recipient's physician or other health care professional concerning the care of that recipient also will be maintained in the recipient's file.

The Department argues that Southaven violated 13 CSR 70-91.010(6)(D) and (F) because the documents produced by Southaven during the audit in support of its separately-authorized nurse visit claims in this case do not, for the audited dates of service, show that an RN performed the services or that an LPN performed the asserted services under the direction of an RN.

The Nursing Assessment Summaries provided by Southaven are one-page documents – a checklist of the condition of each patient each month. For example, the nurse is given a choice under "muscle tone" of checking a box for good, adequate, or poor. The summaries are signed by the client and an LPN. There are no other observations or written notes. Nothing is signed by an RN, and nothing in the documentation refers to supervision by an RN as required by the regulation if the RN is not performing the clients' services. In addition, as was discussed above, there is evidence that some documents were simply photocopied from month to month for a particular client. For example, the document purporting to be a nurse visit record for W.D. in April 2011 completely matches the document purporting to be a nurse visit record for W.D. in May of that year, except for the date. There was evidence of "white-out" used in the date section and a new date written over it. If the records were merely being copied and used in later months, they would not be "made contemporaneously with the delivery of the service" and would not be adequate documentation as defined by 13 CSR 70-3.030(2)(A).

Stoverink argues that she billed for nurse visits based on the documents in Exhibit A. But as discussed above, these documents provide even less support for a separately-authorized nurse visit claim. The personal care logs are still only signed by an LPN (a photocopied signature on many forms) and clearly deal with personal care rather than nursing services.

Stoverink testified that an RN provided care to clients and supervision to Southaven's employees. But this case is about documentation, and Southaven's documentation is inadequate.

Southaven violated 13 CSR 70-3.030(2)(A) and 13 CSR 70-91.010(6)(F) as set forth in our Finding of Fact #19 under Type C errors. Southaven did not violate 13 CSR 70-91.010(6)(D), which sets forth the duties an RN may perform and may supervise, because that regulation cannot be violated. Again, the Department is not arguing that the services were not provided, but that the documentation does not reflect that they were. The Department also cites 13 CSR 70-3.130(1)(E) and (2)(C)4, but these are definitions of "overpayment" and also cannot be violated.

For these violations, the Department argues that Southaven is subject to sanctions under 13 CSR 70-3.030(3)(A)2, 4, and 7.

2. Submitting false information for the purpose of obtaining greater compensation than that to which the provider is entitled under applicable MO HealthNet program policies or rules.

Because the regulation does not define the term "false," we turn to the dictionary to determine the plain meaning of the word. *See E&B Granite, Inc. v. Dir. of Revenue,* 331 S.W.3d 314, 318 (Mo. banc 2011) (Absent a statutory definition, the plain meaning of words used in a statute, as found in the dictionary, is typically relied on); *State ex rel. Evans v. Brown Builders Elec. Co., Inc.*, 254 S.W.3d 31, 35 (Mo. banc 2008) (statutes and regulations are interpreted according to the same rules). The word "false," as found in the dictionary, means:

> **1 a :** not corresponding to the truth or reality **:** not true **:** ERRONEOUS, INCORRECT… **b :** intentionally untrue **:** LYING[.]

WEBSTER'S THIRD NEW INT'L DICTIONARY UNABRIDGED 819 (1986). We do not construe the word "false," as used in the regulation, to include the component of intent. To do so would essentially equate the word to fraud, and render "false" in 13 CSR 7-.030(3)1 mere surplusage.

Southaven submitted false information to obtain compensation for nurse visits, in that it billed for nurse visits when the documentation supporting those visits did not demonstrate that an RN provided the services or supervised the LPN who performed the services. There is cause to sanction Southaven under subsection 2.

4. Failing to keep and make available adequate records. Although Southaven timely and willingly made its records available to the Department, in a number of instances the Department found there was no documentation or inadequate documentation to support the services billed. This is cause to sanction Southaven under subsection 4.

7. Breaching of the terms of the MO HealthNet provider agreement or any current written and published policies and procedures of the MO HealthNet program. Southaven breached its provider agreement by submitting false claims to MO HealthNet and thereby violating Medicaid regulations. There is cause to sanction it under subsection 7.

C. Error Type D – Billing for 31 days in months with less than 31 days

Regulation 13 CSR 70-91.010(1) states:

> (B) Obtaining Personal Care Services.
>
> ***
>
> 2. The personal care plan will be developed in collaboration with and signed by the recipient. The plan will include a list of tasks to be performed, weekly schedule of service delivery, and the maximum number of units of service for which the recipient is eligible per month.
>
> 3. A new in-home assessment and personal care plan may be completed by the Department of Health and Senior Services or its designee as needed to redetermine need for personal care services or to adjust the monthly amount of authorized units. In collaboration with the service recipient, the service agency may develop a new or revised set of personal care tasks, and weekly schedule of service delivery which shall be forwarded to the Department of Health and Senior Services or its designee. The service provider must always have, and provide services in

> accordance with, a current service plan. Only the Department of Health and Senior Services or its designee, not the service provider, may increase the maximum number of units for which the individual is eligible per month. Any service plan developed in accordance with paragraphs (1)(B)2. and 3. is a state approved service plan.
>
> ***
>
> (4) Reimbursement.
>
> (A) Payment will be made in accordance with the fee per unit of service as defined and determined by the Division of Medical Services.
>
> 1. A unit of service is fifteen (15) minutes.

The Department argues that Southaven violated 13 CSR 70-91.010(1)(B)2, (1)(B)3, and (4)(A)1 because those claims sought payment for the monthly maximum of personal care services provided during months having fewer than 31 days. The Department argues that Southaven did not provide the monthly maximum of personal care services – daily tasks performed every day for 31 days – to the client in accordance with the service plan during those months, but billed as if it did provide the services.

Southaven may only provide services in accordance with a personal care plan that sets forth a maximum number of monthly service units that the client is eligible to receive. Stoverink testified that she was provided with the maximum number and billed that amount every month. But it defies logic that a provider would be able to provide the same daily service units, and bill for them, in a month with 28 days as in a month with 31 days.

Southaven violated 13 CSR 70-91.010(1)(B)2, (1)(B)3, and (4)(A)1. For these violations, the Department argues that Southaven is subject to sanctions under 70-3.030(3)(A)2, 4, and 7.

2. Submitting false information for the purpose of obtaining greater compensation than that to which the provider is entitled under applicable MO HealthNet program policies or rules.

Southaven submitted false information to obtain compensation by billing for a full 31 days of service in months that had less than 31 days. There is cause for sanction under subsection 2.

4. Failing to keep and make available adequate records. Although Southaven timely and willingly made its records available to the Department, there was no documentation to support the services billed for the additional days of the month. This is cause to sanction Southaven under subsection 4.

7. Breaching of the terms of the MO HealthNet provider agreement or any current written and published policies and procedures of the MO HealthNet program. Southaven breached its provider agreement by submitting false claims to MO HealthNet and thereby violating Medicaid regulations. There is cause to sanction it under subsection 7.

D. Error Types E and F

The Department argues that Southaven is subject to sanction because there was no documentation in support of these claims or the documentation provided by Southaven was not made at or near the time of the events purportedly recorded.

1. Error Type E – Creating Documentation during the On-site Review

Error Type E involves a failure to provide adequate documentation based on the fact that a Southaven employee was found creating personal care logs during the on-site audit that purported to document services performed before the on-site audit. Southaven does not deny that this occurred. Stoverink testified about the personal care log for client K.K.:

> I'm sorry. I explained that to Mr. Lanigan, and I said yes, I'm not going to lie, she was creating a care log that she had misplaced and

> she was reprimanded for it, but she was providing most of his care and I apologized to Mr. Lanigan.

Tr. at 209-10. These personal care logs cannot be considered adequate documentation.

The Department cites 13 CSR 70-3.030(2)(A), 70-3.130(1)(E) and 70-3.130(2)(C)4, but these are definitions of "overpayment" and cannot be violated. The Department argues that Southaven violated 13 CSR 70-3.030(3)(A)4, 7, 33, 38 and 39.

4. Failing to keep and make available adequate records. Southaven failed to keep and maintain and make the personal care logs timely available upon request. Its nurse was, in fact, creating the logs for May 2011 during the on-site review. There is cause for sanction under subsection 4.

7. Breaching of the terms of the MO HealthNet provider agreement or any current written and published policies and procedures of the MO HealthNet program. Southaven breached its provider agreement by violating Medicaid regulations. There is cause to sanction it under subsection 7.

33. Failing to retain documents for a requisite number of years. Southaven failed to maintain required documentation as noted above. There is cause for sanction under subsection 33.

38. Failure to maintain documentation which is to be made contemporaneously to the date of service. Southaven failed to maintain required documentation as noted above. Since Southaven's nurse was creating the documentation from services that had already been rendered, the documentation was not contemporaneous. There is cause for sanction under this paragraph.

39. Failure to maintain records of services provided and billing done under his/her provider number. Southaven failed to maintain required documentation as noted above. There is cause for sanction under this paragraph.

There is cause for sanctions for violating 13 CSR 70-3.030(3)(A)4, 7, 33, 38 and 39.

2. Error Type F – Missing Documentation

Southaven failed to provide the Department with any documentation in support of certain claims during the audit. As analyzed above, Southaven violated 13 CSR 70-3.030(3)(A)4, 7, 33, 38, and 39.

II. Sanctions – Amount of Overpayment

To determine the appropriate sanction, we consider the criteria set forth in 13 CSR 70-2.030(5)(A): the seriousness of the offenses, the extent of violations, the history of prior violations, prior imposition of sanctions, prior provision of provider education, and actions taken by peer review groups, licensing boards, professional review organizations or utilization review committees. Regulation 13 CSR 70-3.030(5) lists several possible factors to consider in determining the seriousness of the offense, and one of these is harm to the program in the form of an overpayment.

The sanctions for program violations are set forth at 13 CSR 70-3.030(4). The sanctions include withholding of future provider payments, termination or suspension from participation in the Medicaid program, suspension or withholding of payments, referral to peer review committees or utilization committees, recoupment of future payments, education sessions, prior authorization of services, or referral for investigation. Regulation 13 CSR 70-3.030(4)(B) provides for the termination from participation in the Medicaid program for a period of not less than 60 days and not more than 10 years.

Southaven's violations were serious in that the clients' records were inadequate to document the services provided. This resulted in harm to the Medicaid program as the claims for these services were paid without appropriate documentation. Every record supplied by Southaven had a problem of some kind that violated the regulations. Attempting to create

documents long after the services have been provided is not an acceptable way to demonstrate that the services were provided. But the Department has not alleged that Southaven did not actually perform the services. As to past history, Stoverink testified that she had one previous issue with Medicaid, which we regard as minor in nature. There is no evidence of prior sanctions, provider education, or actions taken by other organizations.

We find that recoupment of the overpayment is appropriate. In addition, Stoverink and Southaven should be required to complete such further provider education regarding adequate documentation as the Department sees fit to impose.

Summary

We find that Southaven's inadequate records resulted in an overpayment of $43,524.10 and authorize the Department to recoup this money. In addition, we order that Southaven obtain further provider education as described above.

SO ORDERED on November 4, 2014.

\s\ Karen A. Winn
KAREN A. WINN
Commissioner